suer, if not for the enactment of the Patient Protection and Affordable Care Act and title I and subtitle B of title II of the Health Care and Education Reconciliation Act of 2010.

**(3) Qualified expatriate**

The term ''qualified expatriate'' means a primary insured, or individual otherwise described in subparagraph (C)—

(A)(i) whose skills, qualifications, job duties, or expertise is of a type that has caused his or her employer to transfer or assign him or her to the United States for a specific and temporary purpose or assignment tied to his or her employment; and

(ii) in connection with such transfer or assignment, is reasonably determined by the plan sponsor to require access to health insurance and other related services and support in multiple countries, and is offered other multinational benefits on a periodic basis (such as tax equalization, compensation for cross border moving expenses, or compensation to enable the expatriate to return to their home country);

(B) who is working outside of the United States for a period of at least 180 days in a consecutive 12-month period that overlaps with the plan year; or

(C) who is a member of a group of similarly situated individuals—

(i) that is formed for the purpose of traveling or relocating internationally in service of one or more of the purposes listed in section 501(c)(3) or 501(c)(4) of title 26, or similarly situated organizations or groups (such as students or religious missionaries);

(ii) that is not formed primarily for the sale of health insurance coverage; and

(iii) that the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury and the Secretary of Labor, determines requires access to health insurance and other related services and support in multiple countries.

**(4) United States**

The term ''United States'' means the 50 States, the District of Columbia, and Puerto Rico.

**(5) Miscellaneous terms**

**(A) Group health plan; health insurance coverage; health insurance issuer; plan sponsor**

The terms ''group health plan'', ''health insurance coverage'', ''health insurance issuer'', and ''plan sponsor'' have the meanings given those terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).

**(B) Transfer**

The term ''transfer'' means an employer has transferred an employee to perform services for a branch of the same employer or a parent, affiliate, franchise, or subsidiary thereof.

**(e) Regulations**

The Secretary of the Treasury, the Secretary of Health and Human Services, and the Secretary of Labor may promulgate regulations necessary to carry out this Act, including such rules as may be necessary to prevent inappropriate expansion of the application of the exclusions under this Act from applicable laws and regulations, and to amend existing annual reporting requirements or procedures to include applicable qualified expatriate health insurers' total number of expatriate plan enrollees.

**(f) Effective date**

Unless otherwise specified, this Act shall take effect on December 16, 2014, and shall apply only to expatriate health plans issued or renewed on or after July 1, 2015.

(Pub. L. 113–235, div. M, §3, Dec. 16, 2014, 128 Stat. 2768.)

REFERENCES IN TEXT

The Patient Protection and Affordable Care Act, referred to in subsecs. (a) and (d)(2)(G), is Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 119. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of this title and Tables.

The Health Care and Education Reconciliation Act of 2010, referred to in subsecs. (a) and (d)(2)(G), is Pub. L. 111–152, Mar. 30, 2010, 124 Stat. 1029. For complete classification of this Act to the Code, see Short Title of 2010 Amendment note set out under section 1305 of this title and Tables.

The Public Health Service Act, referred to in subsec. (d)(2)(G), is act July 1, 1944, ch. 373, 58 Stat. 682, which is classified generally to chapter 6A (§201 et seq.) of this title. Title XXVII of the Act is classified generally to subchapter XXV (§300gg et seq.) of chapter 6A. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

The Employee Retirement Income Security Act of 1974, referred to in subsec. (d)(2)(G), is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 832. Part 7 of subtitle B of title I of the Act is classified generally to part 7 (§1181 et seq.) of subtitle B of subchapter I of chapter 18 of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

This Act, referred to in subsecs. (e) and (f), is div. M of Pub. L. 113–235, Dec. 16, 2014, 128 Stat. 2767, known as the Expatriate Health Coverage Clarification Act of 2014. For complete classification of this Act to the Code, see Short Title of 2014 Amendment note set out under section 18001 of this title and Tables.

CODIFICATION

Section was enacted as part of the Expatriate Health Coverage Clarification Act of 2014, and also as part of the Consolidated and Further Continuing Appropriations Act, 2015, and not as part of title I of the Patient Protection and Affordable Care Act which enacted this chapter.

## SUBCHAPTER III—AVAILABLE COVERAGE CHOICES FOR ALL AMERICANS

### PART A—ESTABLISHMENT OF QUALIFIED HEALTH PLANS

### § 18021. Qualified health plan defined

**(a) Qualified health plan**

In this title:[1]

**(1) In general**

The term ''qualified health plan'' means a health plan that—

[1] See References in Text note below.

(A) has in effect a certification (which may include a seal or other indication of approval) that such plan meets the criteria for certification described in section 18031(c) of this title issued or recognized by each Exchange through which such plan is offered;

(B) provides the essential health benefits package described in section 18022(a) of this title; and

(C) is offered by a health insurance issuer that—

(i) is licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage under this title;[1]

(ii) agrees to offer at least one qualified health plan in the silver level and at least one plan in the gold level in each such Exchange;

(iii) agrees to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent; and

(iv) complies with the regulations developed by the Secretary under section 18031(d) of this title and such other requirements as an applicable Exchange may establish.

**(2) Inclusion of CO–OP plans and multi-State qualified health plans**

Any reference in this title[1] to a qualified health plan shall be deemed to include a qualified health plan offered through the CO–OP program under section 18042 of this title, and a multi-State plan under section 18054 of this title, unless specifically provided for otherwise.

**(3) Treatment of qualified direct primary care medical home plans**

The Secretary of Health and Human Services shall permit a qualified health plan to provide coverage through a qualified direct primary care medical home plan that meets criteria established by the Secretary, so long as the qualified health plan meets all requirements that are otherwise applicable and the services covered by the medical home plan are coordinated with the entity offering the qualified health plan.

**(4) Variation based on rating area**

A qualified health plan, including a multi-State qualified health plan, may as appropriate vary premiums by rating area (as defined in section 300gg(a)(2) of this title).

**(b) Terms relating to health plans**

In this title:[1]

**(1) Health plan**

**(A) In general**

The term ''health plan'' means health insurance coverage and a group health plan.

**(B) Exception for self-insured plans and MEWAs**

Except to the extent specifically provided by this title,[1] the term ''health plan'' shall not include a group health plan or multiple employer welfare arrangement to the extent the plan or arrangement is not subject to State insurance regulation under section 1144 of title 29.

**(2) Health insurance coverage and issuer**

The terms ''health insurance coverage'' and ''health insurance issuer'' have the meanings given such terms by section 300gg–91(b) of this title.

**(3) Group health plan**

The term ''group health plan'' has the meaning given such term by section 300gg–91(a) of this title.

(Pub. L. 111–148, title I, §1301, title X, §10104(a), Mar. 23, 2010, 124 Stat. 162, 896.)

REFERENCES IN TEXT

This title, where footnoted in text, is title I of Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 130, which enacted this chapter and enacted, amended, and transferred numerous other sections and notes in the Code. For complete classification of title I to the Code, see Tables.

AMENDMENTS

2010—Subsec. (a)(2) to (4). Pub. L. 111–148, §10104(a), added pars. (2) to (4) and struck out former par. (2). Prior to amendment, text of par. (2) read as follows: ''Any reference in this title to a qualified health plan shall be deemed to include a qualified health plan offered through the CO-OP program under section 18042 of this title or a community health insurance option under section 18043 of this title, unless specifically provided for otherwise.''

## § 18022. Essential health benefits requirements

**(a) Essential health benefits package**

In this title,[1] the term ''essential health benefits package'' means, with respect to any health plan, coverage that—

(1) provides for the essential health benefits defined by the Secretary under subsection (b);

(2) limits cost-sharing for such coverage in accordance with subsection (c); and

(3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

**(b) Essential health benefits**

**(1) In general**

Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

(A) Ambulatory patient services.

(B) Emergency services.

(C) Hospitalization.

(D) Maternity and newborn care.

(E) Mental health and substance use disorder services, including behavioral health treatment.

(F) Prescription drugs.

(G) Rehabilitative and habilitative services and devices.

(H) Laboratory services.

(I) Preventive and wellness services and chronic disease management.

(J) Pediatric services, including oral and vision care.

[1] See References in Text note below.

**(2) Limitation**

**(A) In general**

The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary.

**(B) Certification**

In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in paragraph (2).

**(3) Notice and hearing**

In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall provide notice and an opportunity for public comment.

**(4) Required elements for consideration**

In defining the essential health benefits under paragraph (1), the Secretary shall—

(A) ensure that such essential health benefits reflect an appropriate balance among the categories described in such subsection,[2] so that benefits are not unduly weighted toward any category;

(B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(E) provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits described in paragraph (1) unless the plan provides that—

(i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(ii) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

(F) provide that if a plan described in section 18031(b)(2)(B)(ii)[3] of this title (relating to stand-alone dental benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under paragraph (1)(J); and[4]

(G) periodically review the essential health benefits under paragraph (1), and provide a report to Congress and the public that contains—

(i) an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;

(ii) an assessment of whether the essential health benefits needs to be modified or updated to account for changes in medical evidence or scientific advancement;

(iii) information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base;

(iv) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2); and

(H) periodically update the essential health benefits under paragraph (1) to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in the review conducted under subparagraph (G).

**(5) Rule of construction**

Nothing in this title[1] shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this subsection.

**(c) Requirements relating to cost-sharing**

**(1) Annual limitation on cost-sharing**

**(A) 2014**

The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of title 26 for self-only and family coverage, respectively, for taxable years beginning in 2014.

**(B) 2015 and later**

In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall—

[2] So in original. Probably should be ''paragraph,''.

[3] So in original. Probably should be ''18031(d)(2)(B)(ii)''.

[4] So in original. The word ''and'' probably should not appear.

(i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and

(ii) in the case of other coverage, twice the amount in effect under clause (i).

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

**(2) Repealed. Pub. L. 113–93, title II, § 213(a)(1), Apr. 1, 2014, 128 Stat. 1047**

**(3) Cost-sharing**

In this title—[1]

**(A) In general**

The term ''cost-sharing'' includes—

(i) deductibles, coinsurance, copayments, or similar charges; and

(ii) any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of section 223(d)(2) of title 26) with respect to essential health benefits covered under the plan.

**(B) Exceptions**

Such term does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

**(4) Premium adjustment percentage**

For purposes of paragraph (1)(B)(i), the premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013 (as determined by the Secretary).

**(d) Levels of coverage**

**(1) Levels of coverage defined**

The levels of coverage described in this subsection are as follows:

**(A) Bronze level**

A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

**(B) Silver level**

A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

**(C) Gold level**

A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.

**(D) Platinum level**

A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

**(2) Actuarial value**

**(A) In general**

Under regulations issued by the Secretary, the level of coverage of a plan shall be determined on the basis that the essential health benefits described in subsection (b) shall be provided to a standard population (and without regard to the population the plan may actually provide benefits to).

**(B) Employer contributions**

The Secretary shall issue regulations under which employer contributions to a health savings account (within the meaning of section 223 of title 26) may be taken into account in determining the level of coverage for a plan of the employer.

**(C) Application**

In determining under this title,[1] the Public Health Service Act [42 U.S.C. 201 et seq.], or title 26 the percentage of the total allowed costs of benefits provided under a group health plan or health insurance coverage that are provided by such plan or coverage, the rules contained in the regulations under this paragraph shall apply.

**(3) Allowable variance**

The Secretary shall develop guidelines to provide for a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

**(4) Plan reference**

In this title,[1] any reference to a bronze, silver, gold, or platinum plan shall be treated as a reference to a qualified health plan providing a bronze, silver, gold, or platinum level of coverage, as the case may be.

**(e) Catastrophic plan**

**(1) In general**

A health plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of subsection (d) with respect to any plan year if—

(A) the only individuals who are eligible to enroll in the plan are individuals described in paragraph (2); and

(B) the plan provides—

(i) except as provided in clause (ii), the essential health benefits determined under subsection (b), except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (c)(1) for the plan year (except as provided for in section 2713);[1] and

(ii) coverage for at least three primary care visits.

**(2) Individuals eligible for enrollment**

An individual is described in this paragraph for any plan year if the individual—

(A) has not attained the age of 30 before the beginning of the plan year; or

(B) has a certification in effect for any plan year under this title[1] that the individual is exempt from the requirement under section 5000A of title 26 by reason of—

(i) section 5000A(e)(1) of such title (relating to individuals without affordable coverage); or

(ii) section 5000A(e)(5) of such title (relating to individuals with hardships).

**(3) Restriction to individual market**

If a health insurance issuer offers a health plan described in this subsection, the issuer may only offer the plan in the individual market.

**(f) Child-only plans**

If a qualified health plan is offered through the Exchange in any level of coverage specified under subsection (d), the issuer shall also offer that plan through the Exchange in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21, and such plan shall be treated as a qualified health plan.

**(g) Payments to Federally-qualified health centers**

If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1396d(*l*)(2)(B) of this title) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1396a(bb) of this title) for such item or service.

(Pub. L. 111–148, title I, §1302, title X, §10104(b), Mar. 23, 2010, 124 Stat. 163, 896; Pub. L. 113–93, title II, §213(a), Apr. 1, 2014, 128 Stat. 1047.)

REFERENCES IN TEXT

This title, referred to in subsecs. (a), (b)(5), (d)(2)(C), (4), and (e)(2)(B), is title I of Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 130, which enacted this chapter and enacted, amended, and transferred numerous other sections and notes in the Code. For complete classification of title I to the Code, see Tables.

The Public Health Service Act, referred to in subsec. (d)(2)(C), is act July 1, 1944, ch. 373, 58 Stat. 682, which is classified generally to chapter 6A (§201 et seq.) of this title. For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

Section 2713, referred to in subsec. (e)(1)(B)(i), probably means section 2713 of act July 1, 1944, which is classified to section 300gg–13 of this title.

AMENDMENTS

2014—Subsec. (c)(2). Pub. L. 113–93, §213(a)(1), struck out par. (2) which related to annual limitation on deductibles for employer-sponsored plans.

Subsec. (c)(4). Pub. L. 113–93, §213(a)(2), which directed amendment of par. (4)(A) by substituting ''paragraph (1)(B)(i)'' for ''paragraphs (1)(B)(i) and (2)(B)(i)'', was executed by making the substitution in par. (4) to reflect the probable intent of Congress.

2010—Subsec. (d)(2)(B). Pub. L. 111–148, §10104(b)(1), substituted ''shall issue'' for ''may issue''.

Subsec. (g). Pub. L. 111–148, §10104(b)(2), added subsec. (g).

EFFECTIVE DATE OF 2014 AMENDMENT

Amendment by Pub. L. 113–93 effective as if included in the enactment of Pub. L. 111–148, see section 213(c) of Pub. L. 113–93, set out as a note under section 300gg–6 of this title.

## § 18023. Special rules

**(a) State opt-out of abortion coverage**

**(1) In general**

A State may elect to prohibit abortion coverage in qualified health plans offered through an Exchange in such State if such State enacts a law to provide for such prohibition.

**(2) Termination of opt out**

A State may repeal a law described in paragraph (1) and provide for the offering of such services through the Exchange.

**(b) Special rules relating to coverage of abortion services**

**(1) Voluntary choice of coverage of abortion services**

**(A) In general**

Notwithstanding any other provision of this title[1] (or any amendment made by this title)—[1]

(i) nothing in this title[1] (or any amendment made by this title),[1] shall be construed to require a qualified health plan to provide coverage of services described in subparagraph (B)(i) or (B)(ii) as part of its essential health benefits for any plan year; and

(ii) subject to subsection (a), the issuer of a qualified health plan shall determine whether or not the plan provides coverage of services described in subparagraph (B)(i) or (B)(ii) as part of such benefits for the plan year.

**(B) Abortion services**

**(i) Abortions for which public funding is prohibited**

The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

**(ii) Abortions for which public funding is allowed**

The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

**(2) Prohibition on the use of Federal funds**

**(A) In general**

If a qualified health plan provides coverage of services described in paragraph (1)(B)(i), the issuer of the plan shall not use any amount attributable to any of the following for purposes of paying for such services:

(i) The credit under section 36B of title 26 (and the amount (if any) of the advance

[1] See References in Text note below.

payment of the credit under section 18082 of this title).

(ii) Any cost-sharing reduction under section 18071 of this title (and the amount (if any) of the advance payment of the reduction under section 18082 of this title).

**(B) Establishment of allocation accounts**

In the case of a plan to which subparagraph (A) applies, the issuer of the plan shall—

(i) collect from each enrollee in the plan (without regard to the enrollee's age, sex, or family status) a separate payment for each of the following:

(I) an amount equal to the portion of the premium to be paid directly by the enrollee for coverage under the plan of services other than services described in paragraph (1)(B)(i) (after reduction for credits and cost-sharing reductions described in subparagraph (A)); and

(II) an amount equal to the actuarial value of the coverage of services described in paragraph (1)(B)(i), and

(ii) shall[2] deposit all such separate payments into separate allocation accounts as provided in subparagraph (C).

In the case of an enrollee whose premium for coverage under the plan is paid through employee payroll deposit, the separate payments required under this subparagraph shall each be paid by a separate deposit.

**(C) Segregation of funds**

**(i) In general**

The issuer of a plan to which subparagraph (A) applies shall establish allocation accounts described in clause (ii) for enrollees receiving amounts described in subparagraph (A).

**(ii) Allocation accounts**

The issuer of a plan to which subparagraph (A) applies shall deposit—

(I) all payments described in subparagraph (B)(i)(I) into a separate account that consists solely of such payments and that is used exclusively to pay for services other than services described in paragraph (1)(B)(i); and

(II) all payments described in subparagraph (B)(i)(II) into a separate account that consists solely of such payments and that is used exclusively to pay for services described in paragraph (1)(B)(i).

**(D) Actuarial value**

**(i) In general**

The issuer of a qualified health plan shall estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under the qualified health plan of the services described in paragraph (1)(B)(i).

**(ii) Considerations**

In making such estimate, the issuer—

(I) may take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care;

(II) shall estimate such costs as if such coverage were included for the entire population covered; and

(III) may not estimate such a cost at less than $1 per enrollee, per month.

**(E) Ensuring compliance with segregation requirements**

**(i) In general**

Subject to clause (ii), State health insurance commissioners shall ensure that health plans comply with the segregation requirements in this subsection through the segregation of plan funds in accordance with applicable provisions of generally accepted accounting requirements, circulars on funds management of the Office of Management and Budget, and guidance on accounting of the Government Accountability Office.

**(ii) Clarification**

Nothing in clause (i) shall prohibit the right of an individual or health plan to appeal such action in courts of competent jurisdiction.

**(3) Rules relating to notice**

**(A) Notice**

A qualified health plan that provides for coverage of the services described in paragraph (1)(B)(i) shall provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage.

**(B) Rules relating to payments**

The notice described in subparagraph (A), any advertising used by the issuer with respect to the plan, any information provided by the Exchange, and any other information specified by the Secretary shall provide information only with respect to the total amount of the combined payments for services described in paragraph (1)(B)(i) and other services covered by the plan.

**(4) No discrimination on basis of provision of abortion**

No qualified health plan offered through an Exchange may discriminate against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions[3]

**(c) Application of State and Federal laws regarding abortion**

**(1) No preemption of State laws regarding abortion**

Nothing in this Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor.

[2] So in original. The word ''shall'' probably should not appear.

[3] So in original. Probably should be followed by a period.

**(2) No effect on Federal laws regarding abortion**

**(A)[4] In general**

Nothing in this Act shall be construed to have any effect on Federal laws regarding—

(i) conscience protection;

(ii) willingness or refusal to provide abortion; and

(iii) discrimination on the basis of the willingness or refusal to provide, pay for, cover, or refer for abortion or to provide or participate in training to provide abortion.

**(3) No effect on Federal civil rights law**

Nothing in this subsection shall alter the rights and obligations of employees and employers under title VII of the Civil Rights Act of 1964 [42 U.S.C. 2000e et seq.].

**(d) Application of emergency services laws**

Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1395dd of this title (popularly known as ''EMTALA'').

(Pub. L. 111–148, title I, §1303, title X, §10104(c), Mar. 23, 2010, 124 Stat. 168, 896.)

REFERENCES IN TEXT

This title, referred to in subsec. (b)(1)(A), is title I of Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 130, which enacted this chapter and enacted, amended, and transferred numerous other sections and notes in the Code. For complete classification of title I to the Code, see Tables.

This Act, referred to in subsecs. (c)(1), (2)(A) and (d), is Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 119, known as the Patient Protection and Affordable Care Act. For complete classification of this Act to the Code, see Short Title note set out under section 18001 of this title and Tables.

The Civil Rights Act of 1964, referred to in subsec. (c)(3), is Pub. L. 88–352, July 2, 1964, 78 Stat. 241. Title VII of the Act is classified generally to subchapter VI (§2000e et seq.) of chapter 21 of this title. For complete classification of this Act to the Code, see Short Title note set out under section 2000a of this title and Tables.

AMENDMENTS

2010—Pub. L. 111–148, §10104(c), amended section generally. Prior to amendment, section consisted of subsecs. (a) to (c) relating to special rules relating to coverage of abortion services, application of State and Federal laws regarding abortion, and application of emergency services laws.

EX. ORD. NO. 13535. ENSURING ENFORCEMENT AND IMPLEMENTATION OF ABORTION RESTRICTIONS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

Ex. Ord. No. 13535, Mar. 24, 2010, 75 F.R. 15599, provided:

By the authority vested in me as President by the Constitution and the laws of the United States of America, including the ''Patient Protection and Affordable Care Act'' (Public Law 111–148), I hereby order as follows:

SECTION. 1. *Policy*. Following the recent enactment of the Patient Protection and Affordable Care Act (the ''Act''), it is necessary to establish an adequate enforcement mechanism to ensure that Federal funds are not used for abortion services (except in cases of rape or incest, or when the life of the woman would be endangered), consistent with a longstanding Federal statutory restriction that is commonly known as the Hyde Amendment. The purpose of this order is to establish a comprehensive, Government-wide set of policies and procedures to achieve this goal and to make certain that all relevant actors—Federal officials, State officials (including insurance regulators) and health care providers—are aware of their responsibilities, new and old.

The Act maintains current Hyde Amendment restrictions governing abortion policy and extends those restrictions to the newly created health insurance exchanges. Under the Act, longstanding Federal laws to protect conscience (such as the Church Amendment, 42 U.S.C. 300a–7, and the Weldon Amendment, section 508(d)(1) of Public Law 111–8) remain intact and new protections prohibit discrimination against health care facilities and health care providers because of an unwillingness to provide, pay for, provide coverage of, or refer for abortions.

Numerous executive agencies have a role in ensuring that these restrictions are enforced, including the Department of Health and Human Services (HHS), the Office of Management and Budget (OMB), and the Office of Personnel Management.

SEC. 2. *Strict Compliance with Prohibitions on Abortion Funding in Health Insurance Exchanges*. The Act specifically prohibits the use of tax credits and cost-sharing reduction payments to pay for abortion services (except in cases of rape or incest, or when the life of the woman would be endangered) in the health insurance exchanges that will be operational in 2014. The Act also imposes strict payment and accounting requirements to ensure that Federal funds are not used for abortion services in exchange plans (except in cases of rape or incest, or when the life of the woman would be endangered) and requires State health insurance commissioners to ensure that exchange plan funds are segregated by insurance companies in accordance with generally accepted accounting principles, OMB funds management circulars, and accounting guidance provided by the Government Accountability Office.

I hereby direct the Director of the OMB and the Secretary of HHS to develop, within 180 days of the date of this order, a model set of segregation guidelines for State health insurance commissioners to use when determining whether exchange plans are complying with the Act's segregation requirements, established in section 1303 of the Act, for enrollees receiving Federal financial assistance. The guidelines shall also offer technical information that States should follow to conduct independent regular audits of insurance companies that participate in the health insurance exchanges. In developing these model guidelines, the Director of the OMB and the Secretary of HHS shall consult with executive agencies and offices that have relevant expertise in accounting principles, including, but not limited to, the Department of the Treasury, and with the Government Accountability Office. Upon completion of those model guidelines, the Secretary of HHS should promptly initiate a rulemaking to issue regulations, which will have the force of law, to interpret the Act's segregation requirements, and shall provide guidance to State health insurance commissioners on how to comply with the model guidelines.

SEC. 3. *Community Health Center Program*. The Act establishes a new Community Health Center (CHC) Fund within HHS, which provides additional Federal funds for the community health center program. Existing law prohibits these centers from using Federal funds to provide abortion services (except in cases of rape or incest, or when the life of the woman would be endangered), as a result of both the Hyde Amendment and longstanding regulations containing the Hyde language. Under the Act, the Hyde language shall apply to the authorization and appropriations of funds for Community Health Centers under section 10503 and all other relevant provisions. I hereby direct the Secretary of HHS to ensure that program administrators and recipients of Federal funds are aware of and comply with the limitations on abortion services imposed on CHCs by existing law.

[4] So in original. There is no subpar. (B).

Such actions should include, but are not limited to, updating Grant Policy Statements that accompany CHC grants and issuing new interpretive rules.

SEC. 4. *General Provisions*. (a) Nothing in this order shall be construed to impair or otherwise affect: (i) authority granted by law or Presidential directive to an agency, or the head thereof; or (ii) functions of the Director of the OMB relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees or agents, or any other person.

BARACK OBAMA.

### § 18024. Related definitions

#### (a) Definitions relating to markets

In this title:[1]

**(1) Group market**

The term ''group market'' means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by an employer.

**(2) Individual market**

The term ''individual market'' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

**(3) Large and small group markets**

The terms ''large group market'' and ''small group market'' mean the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer (as defined in subsection (b)(1)) or by a small employer (as defined in subsection (b)(2)), respectively.

#### (b) Employers

In this title:[1]

**(1) Large employer**

The term ''large employer'' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

**(2) Small employer**

The term ''small employer'' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

**(3) State option to extend definition of small employer**

Notwithstanding paragraphs (1) and (2), nothing in this section shall prevent a State from applying this subsection by treating as a small employer, with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

**(4) Rules for determining employer size**

For purposes of this subsection—

**(A) Application of aggregation rule for employers**

All persons treated as a single employer under subsection (b), (c), (m), or (*o*) of section 414 of title 26 shall be treated as 1 employer.

**(B) Employers not in existence in preceding year**

In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

**(C) Predecessors**

Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

**(D) Continuation of participation for growing small employers**

If—

(i) a qualified employer that is a small employer makes enrollment in qualified health plans offered in the small group market available to its employees through an Exchange; and

(ii) the employer ceases to be a small employer by reason of an increase in the number of employees of such employer;

the employer shall continue to be treated as a small employer for purposes of this subchapter for the period beginning with the increase and ending with the first day on which the employer does not make such enrollment available to its employees.

#### (c) Secretary

In this title,[1] the term ''Secretary'' means the Secretary of Health and Human Services.

#### (d) State

In this title,[1] the term ''State'' means each of the 50 States and the District of Columbia.

#### (e) Educated health care consumers

The term ''educated health care consumer'' means an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical, and scientific matters.

(Pub. L. 111–148, title I, §1304, title X, §10104(d), Mar. 23, 2010, 124 Stat. 171, 900; Pub. L. 114–60, §2(a), Oct. 7, 2015, 129 Stat. 543.)

REFERENCES IN TEXT

This title, referred to in subsecs. (a) to (d), is title I of Pub. L. 111–148, Mar. 23, 2010, 124 Stat. 130, which en-

[1] See References in Text note below.

acted this chapter and enacted, amended, and transferred numerous other sections and notes in the Code. For complete classification of title I to the Code, see Tables.

AMENDMENTS

2015—Subsec. (b)(1). Pub. L. 114–60, §2(a)(1), substituted ''51'' for ''101''.

Subsec. (b)(2). Pub. L. 114–60, §2(a)(2), substituted ''50'' for ''100''.

Subsec. (b)(3). Pub. L. 114–60, §2(a)(3), amended par. (3) generally. Prior to amendment, text read as follows: ''In the case of plan years beginning before January 1, 2016, a State may elect to apply this subsection by substituting '51 employees' for '101 employees' in paragraph (1) and by substituting '50 employees' for '100 employees' in paragraph (2).''

2010—Subsec. (e). Pub. L. 111–148, §10104(d), added subsec. (e).

PART B—CONSUMER CHOICES AND INSURANCE COMPETITION THROUGH HEALTH BENEFIT EXCHANGES

## § 18031. Affordable choices of health benefit plans

### (a) Assistance to States to establish American Health Benefit Exchanges

#### (1) Planning and establishment grants

There shall be appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, an amount necessary to enable the Secretary to make awards, not later than 1 year after March 23, 2010, to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

#### (2) Amount specified

For each fiscal year, the Secretary shall determine the total amount that the Secretary will make available to each State for grants under this subsection.

#### (3) Use of funds

A State shall use amounts awarded under this subsection for activities (including planning activities) related to establishing an American Health Benefit Exchange, as described in subsection (b).

#### (4) Renewability of grant

##### (A) In general

Subject to subsection (d)(4), the Secretary may renew a grant awarded under paragraph (1) if the State recipient of such grant—

(i) is making progress, as determined by the Secretary, toward—

(I) establishing an Exchange; and

(II) implementing the reforms described in subtitles A and C (and the amendments made by such subtitles); and

(ii) is meeting such other benchmarks as the Secretary may establish.

##### (B) Limitation

No grant shall be awarded under this subsection after January 1, 2015.

#### (5) Technical assistance to facilitate participation in SHOP Exchanges

The Secretary shall provide technical assistance to States to facilitate the participation of qualified small businesses in such States in SHOP Exchanges.

### (b) American Health Benefit Exchanges

#### (1) In general

Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title[1] as an ''Exchange'') for the State that—

(A) facilitates the purchase of qualified health plans;

(B) provides for the establishment of a Small Business Health Options Program (in this title[1] referred to as a ''SHOP Exchange'') that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State; and

(C) meets the requirements of subsection (d).

#### (2) Merger of individual and SHOP Exchanges

A State may elect to provide only one Exchange in the State for providing both Exchange and SHOP Exchange services to both qualified individuals and qualified small employers, but only if the Exchange has adequate resources to assist such individuals and employers.

### (c) Responsibilities of the Secretary

#### (1) In general

The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum—

(A) meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;

(B) ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Service Act [42 U.S.C. 300gg–1(c)]), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;

(C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act [42 U.S.C. 256b(a)(4)] and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act [42 U.S.C. 1396r–8(c)(1)(D)(i)(IV)] as set forth by section 221 of Public Law 111–8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure;

(D)(i) be accredited with respect to local performance on clinical quality measures

[1] See References in Text note below.